Penn Medicine
Lancaster General Health
Ann B. Barshinger Cancer Institute

CMS Oncology Care Model's Standards for Patient Navigation

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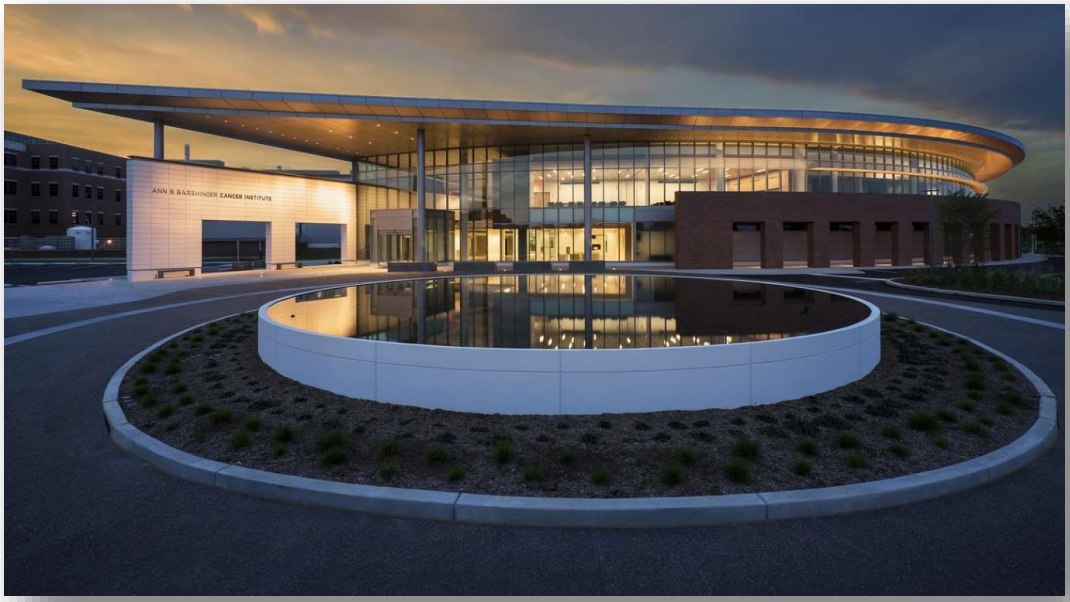
Ann B Barshinger Health Cancer Institute scale and scope



- All outpatient cancer care is together under one roof

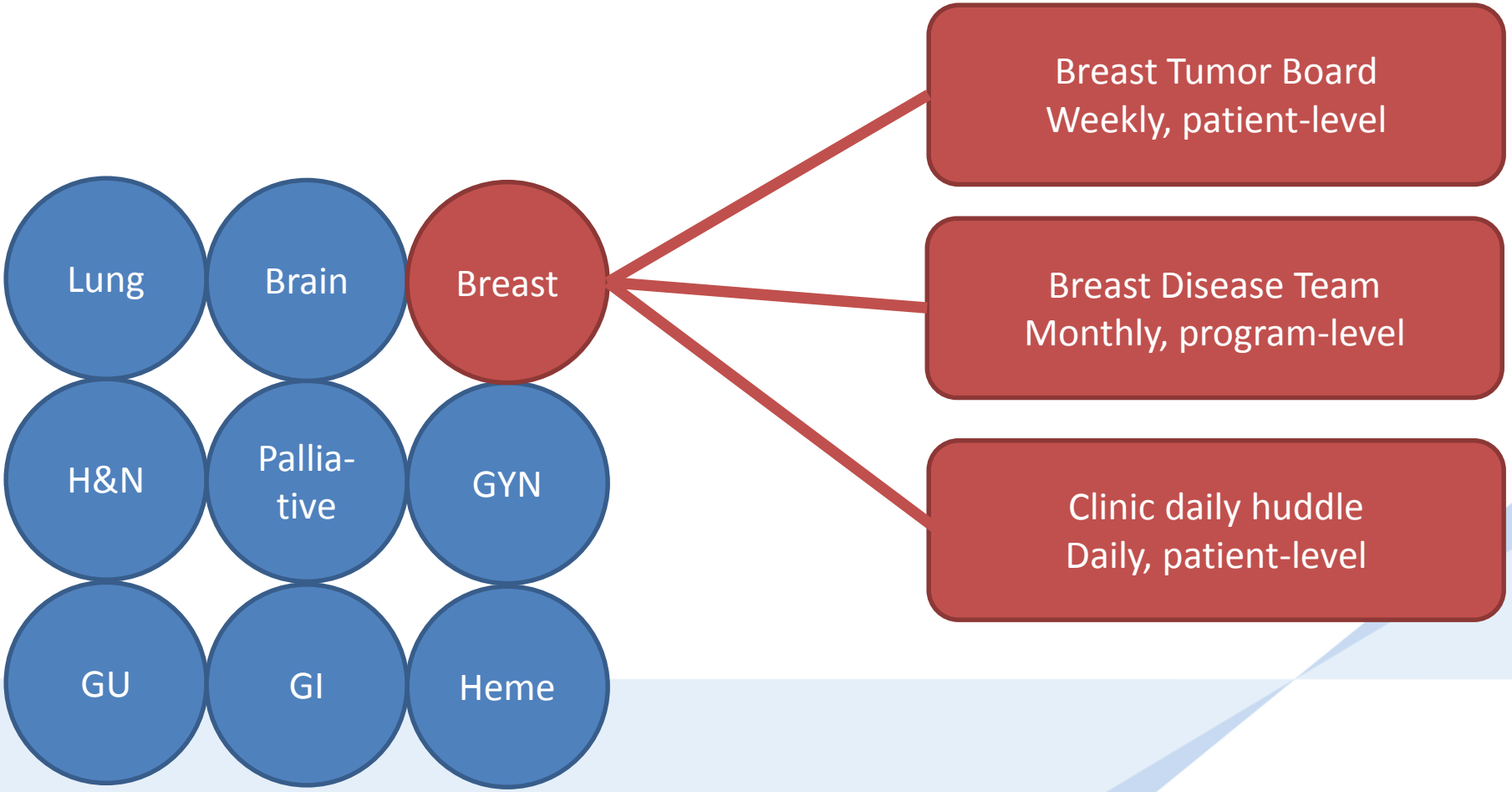
- 100,000 square feet
- 400 encounters per day
- 20 new patients per day

- Infusion Therapy
  - 35 treatment chairs, 6 draw stations

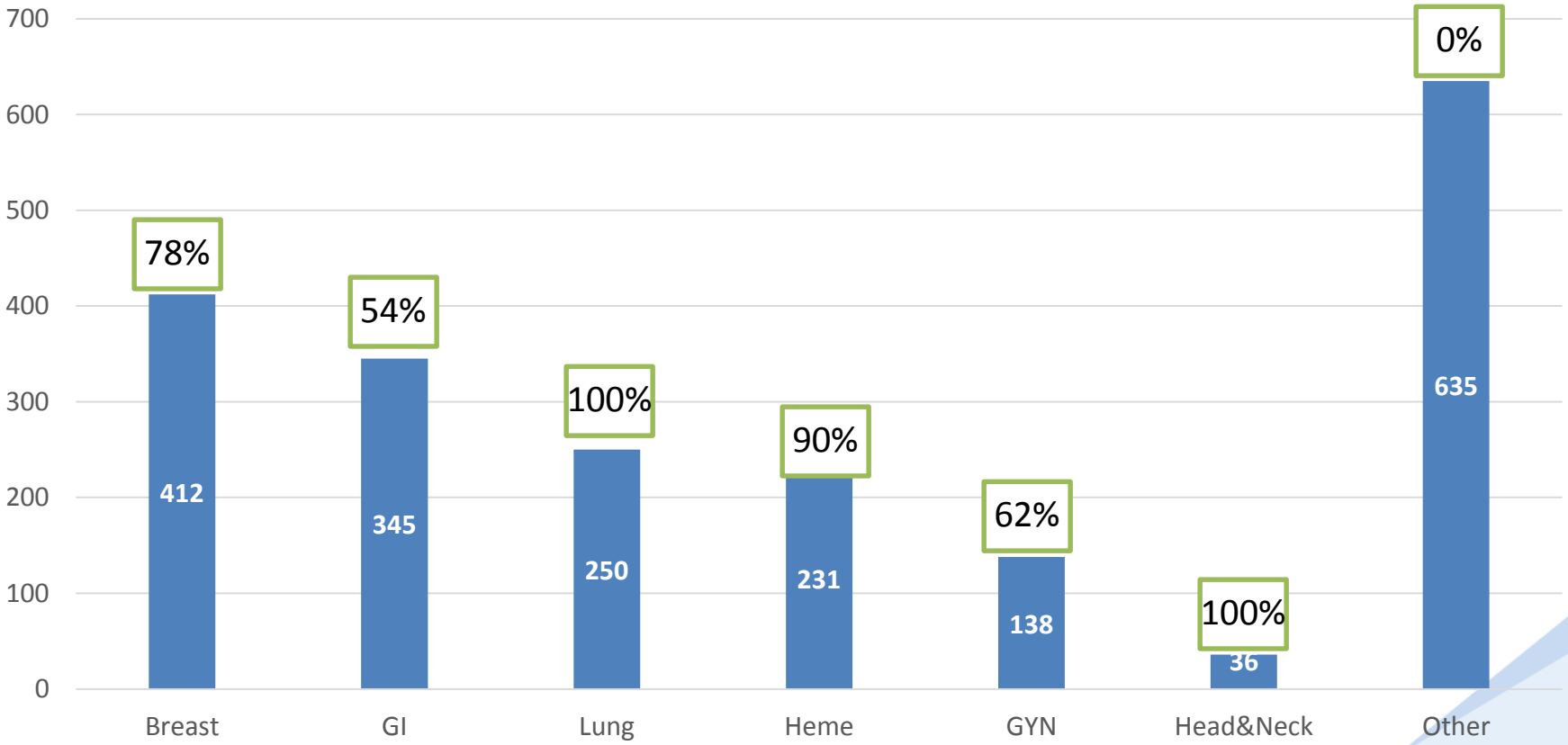
- Radiation Therapy
  - 6 vaults: 2 Linacs, CyberKnife, Gamma Knife, Tomotherapy, HDR/orthovoltage

- Clinic
  - 5 clinics with total of 45 exam rooms, plus 10 consult rooms for education and support services

Integration of navigators in cancer program



Patients with nurse navigators by tumor sit before OCM



Clinical support services staffing

Med onc: 9.0
Gyn onc: 1.5
Rad onc: 4.0
Surg onc: 4.0

Role	Before OCM	Current
Nurse navigator	4.5	7
Dietitian	2	2
Social work	2	4
Financial counselor	1	3
Chaplain	2	2
Secretary	1	2

Impact of OCM on navigation

CMS Oncology Care Model

- **First major alternative payment model in cancer**
  - Program goal is to find practices that can achieve the triple aim
  - Shared savings on risk-adjusted bundled episodes of care
  - Shared savings are at risk for quality and patient experience scores
  - Patient must be receiving outpatient chemotherapy
  - New billable coordination of care fees for OCM patients ($160 PMPM)
  - 6 mandatory practice care transformation requirements
  - Some commercial payers participating with companion plans for their beneficiaries

Requirements for OCM practices

1. Certified Electronic Medical Record
2. Provide 24/7 access to clinician with real-time access to the EMR
3. Use data for continuous quality improvement
4. Treatments are consistent with nationally recognized clinical guidelines
5. Document a care plan that contains the 13 components in the Institute of Medicine Care Management Plan
6. **Provide core functions of patient navigation**

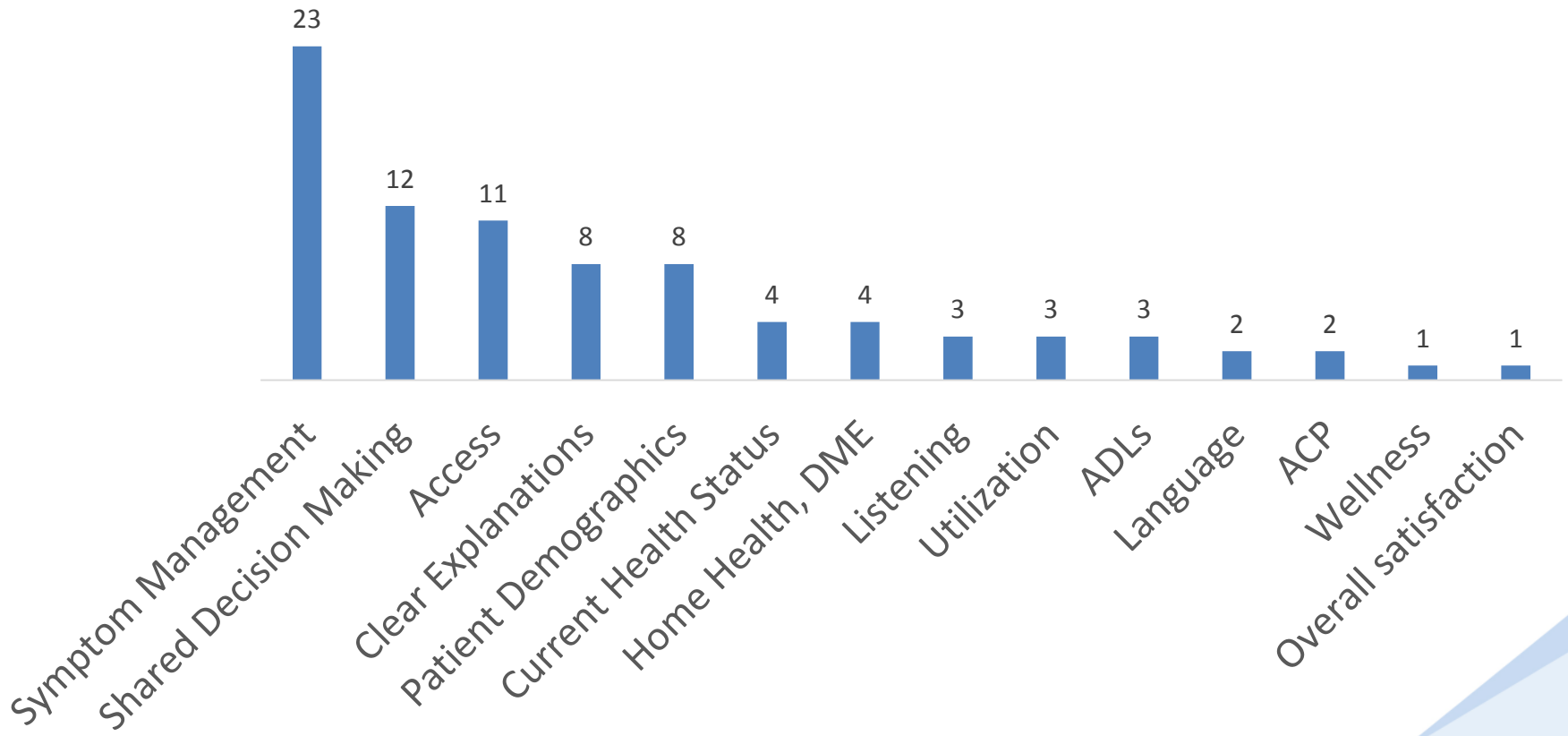
OCM navigation functions

Functions
Coordinate appointments with providers for timely diagnostic and treatment services
Maintain **communication** with patients, survivors, families, and providers to monitor patient experience
Ensure appropriate **medical records** are available at appointments
Arrange **language** translation services
Facilitate **follow-up** services
Provide access to **clinical trials**
Build **partnerships** with local agencies and groups

OCM quality measures

- All-cause admissions
- All-cause emergency department visits
- Patients dying without hospice
- Pain measurement and plan of care
- Depression screening and plan of care
- End of life preference documents

Oncology CAHPS Survey Question Analysis



Challenges

OCM addresses historical navigation challenges

Paying for new navigators

- New OCM Care Coordination fee

Physician engagement

- Requirements and incentives for OCM physicians

Challenges that take on new importance under OCM

- Are we providing help that will have a lasting, measurable benefit to the patient?
- Are we prioritizing the help that we can provide?
- Are we prioritizing the patients we will see?
- Are we providing support to everyone that needs it?
- Do clinical support staff have timely information to make these decisions?
- How do we get data out of the EMR?
- Are there guidelines for doing this the right way?

Meeting OCM requirements

Meeting the navigation requirements

Function	Responsible individual
Coordinate appointments with providers for timely diagnostic and treatment services	Navigator, scheduler
Maintain **communication** with patients, survivors, families, and providers	Navigator
Ensure appropriate **medical records** are available at appointments	Medical records clerk
Arrange **language** translation services	Scheduler
Facilitate **follow-up** services	Scheduler
Provide access to **clinical trials**	Clinical trials nurse
Build **partnerships** with local agencies and groups	Navigator, social work

Identifying who to navigate

Reactive

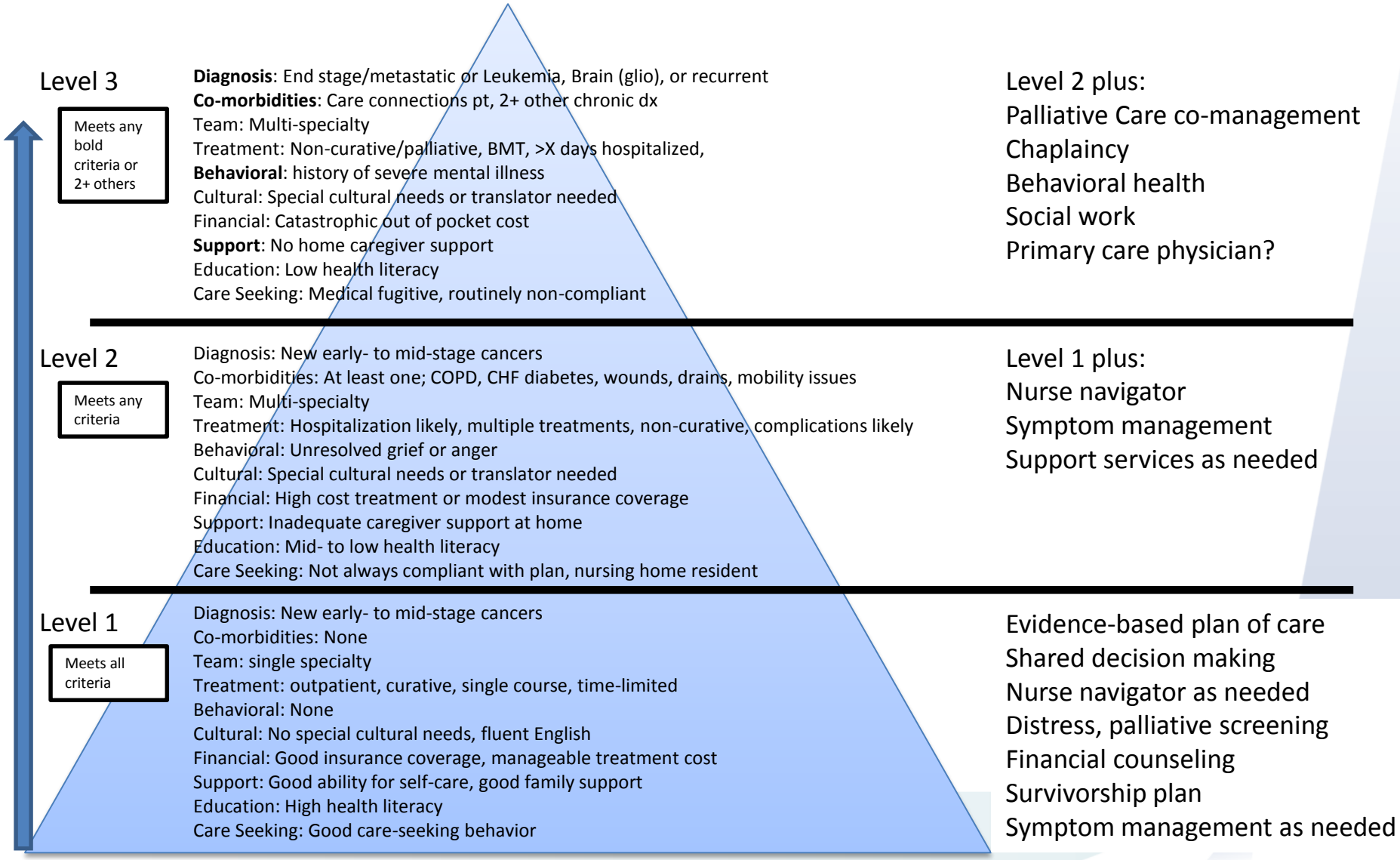
Wait for referral
Wait for patient to self-identify problem

Proactive

Routinely screen for key issues
Key milestones or events automatically trigger referral

Better manage high-risk patients

Lancaster risk-based care model



What does next generation patient navigation look like?

- Prioritization of tasks and patients based on volume, acuity
- Proactive identification of patients requiring services
- Predictive risk modeling
- Access to information on problems facing individual patients and the care continuum
- Ability to better integrate with individual departments as needed
- Clear standards defined for
  - patient progression through the care continuum
  - how to address common barriers for patients
  - how to minimize adverse outcomes
  - how to effectively educate patients
  - key expectations to manage
  - when/how to screen for issues

How can we reduce the need for navigation?

Patient barriers
Provider barriers
Health system barriers

Eliminating provider and system barriers

Key opportunities to achieve the triple aim

- **Patient Engagement**
  - Using **Shared Decision Making** to engage patients in treatment decisions
  - Using **Advance Care Planning** to make end of life decisions ahead of time

- **Care Coordination**
  - Standardized **symptom management** to reduce ED visits
  - Standardized **arrival assessments** to identify patients at risk
  - Daily **team huddles** to prioritize work and highlight gaps

- **End of Life Care**
  - Improving use of hospice and palliative care
  - Reducing unhelpful treatment at end of life

- **Utilization**
  - Developing and using clinical pathways to manage high cost / high risk decisions
  - Moving care to the lowest appropriate care setting
  - Using an oncology drug formulary to limit use of costly drugs with low efficacy

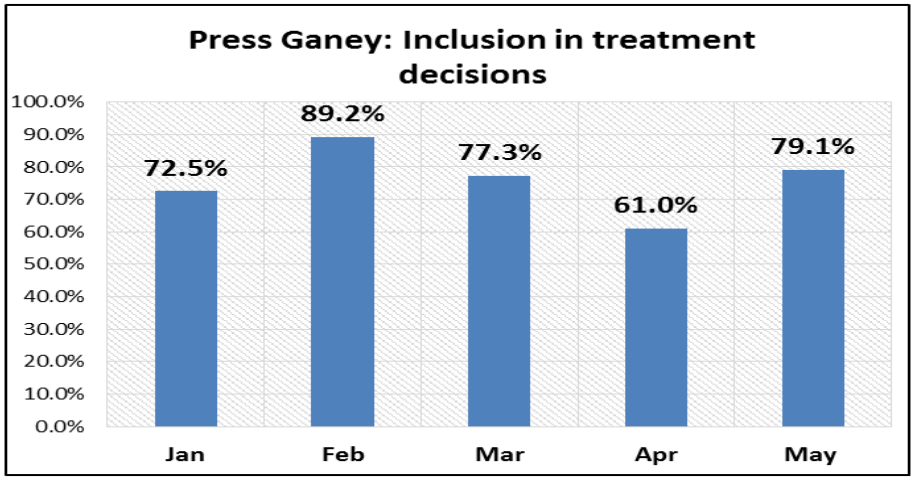
Patient Engagement // IOM Care Plan Template

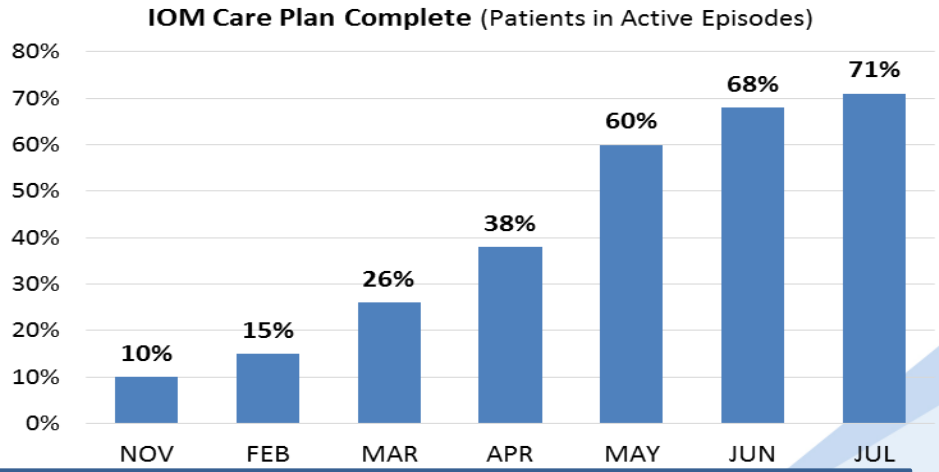
Problem

- Patients may not be aware of their choices
- Patients may have an incorrect understanding of their diagnosis and prognosis
- IOM care plans not being completed 100%
- No single EHR location for IOM plan elements
- Difficult to measure if IOM care plans completed
- Care plan documents not routinely provided to patients
- Care plans were not in patient-friendly language

Solution IOM Care Plan template

- Train staff on Shared Decision
- Some items auto-populated from chart
- Template available for review in all care settings.
- Care plan provided to all providers on care team via follow-up letters
- Patient friendly, easy to understand terms
- Given to patients at time of creation or at treatment education and consent appointment





Future Enhancements:

- Develop best practice for providing to patients
- Automatically embed IOM care plan into After Visit Summary
- Improved language in consent forms

IOM Care Plan Template

Auto Populated

Auto Populated

Auto Populated

Diagnosis Stage	Renal cell carcinoma, right [C64.1] Prostate CA: AJCC edition 7, cStage IIB (T2aN0M0), PSA 8.72 (12/6/12), Gleason 4+4 (6/12 bxs positive all from left 1-18-13) prostate ACA. AUA=3 Prostate size 50.4 cc Staging form: PROSTATE AJCC V7 Clinical: T2a, N0, M0 - Signed by [redacted] on 12/1/2016 Stage IV (T4N1M1) renal cell carcinoma with sarcomatoid features. Treatment plan = Palliative. Staging form: KIDNEY AJCC V7 Clinical stage from 5/23/2016: Stage IV (T4, N1, M1) - Signed by [redacted] on 6/5/2016
Prognosis	Your cancer cannot be cured with treatments we have available today, however it may be controlled for months or years.
Treatment goals/expected response to treatment.	Your cancer cannot be cured, so the goal of treatment is to control your cancer. Treatment to control your cancer can improve bothersome symptoms and may help you live longer. The potential benefit from therapy should be carefully weighed against the side effects.
Quality of life on treatment/patients likely experience	You are likely to feel well on this therapy and will be able to do most of the activities you usually do, no matter how active you were before treatment.
Current Treatment Plan	Anticancer therapy: opdivo How it is given: Intravenous (IV) Number of cycles: as long as working A Cycle equals: 1 day(s) per week every 2 week(s) Surgery: possible cytoreductive nephrectomy Radiation: no Other options discussed:
Who to call with a problem while on therapy:	Call us first with any symptoms that occur while on therapy Pod 3 Orange: 544-9531 or after office hours call Main ABBCI: 544-9400; For scheduling issues call 544-9496 Call your regular physician for refills on medications you were already on before therapy. Continue follow up for other medical problems with your regular physicians.
We recommend a referral with these support services:	For more information, speak with a member of your cancer care team. nursing team
Advanced Care Planning tools in place:	Yes

End of Life Care // Advanced Care Planning (ACP)

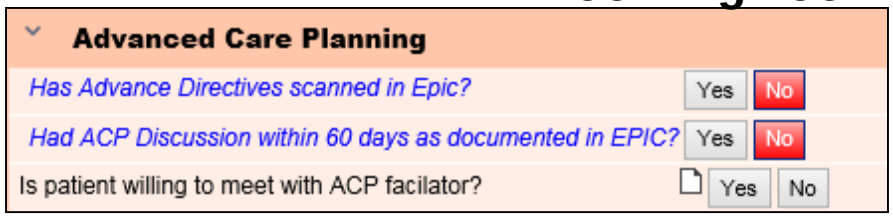
Problem

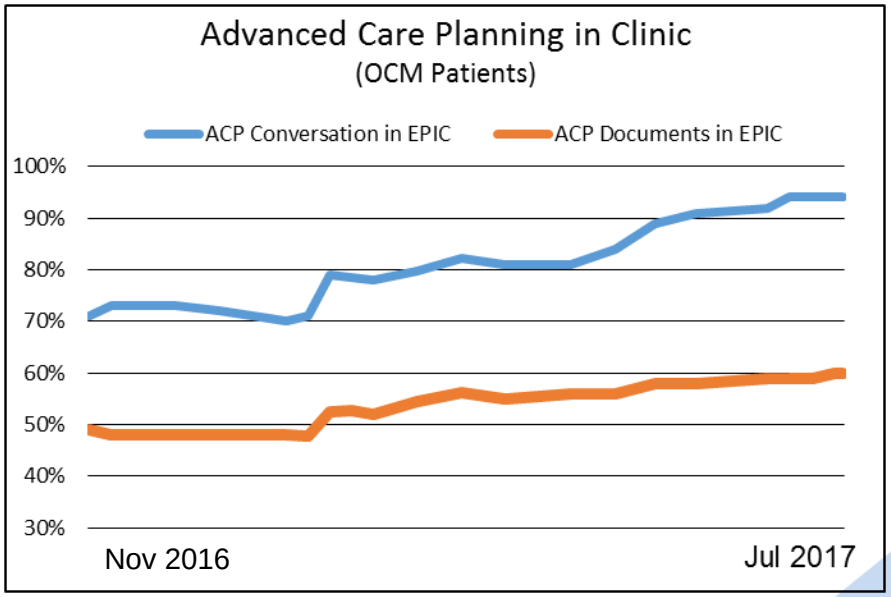
- Too many patients dying in the hospital
- Too many patients receiving chemo at end of life
- No single location in chart for ACP information
- ACP conversations not necessarily translating into patients returning ACP documents

Solution

- Adopted Respecting Choices program
- Educated providers and staff on ACP program
- Created clinic workflow to identify patients needing ACP
- Trained ACP facilitators – each clinic area has designed facilitators
- Epic enhancements including ACP referrals, standard location in chart, and flag in pt header
- Provide pts a SASE for return of ACP documents
- ACP indicator built into Rooming Tool

Rooming Tool





Future Enhancements:

- Explore process for Out of Hospital DNR
- Update ACP referral

Care Coordination // Symptom Management

Problem

- Patients who go to ED or are admitted for oncology symptom issues resulting in higher cost of care.
- Many side effects and symptoms can be managed at home or in the outpatient setting.

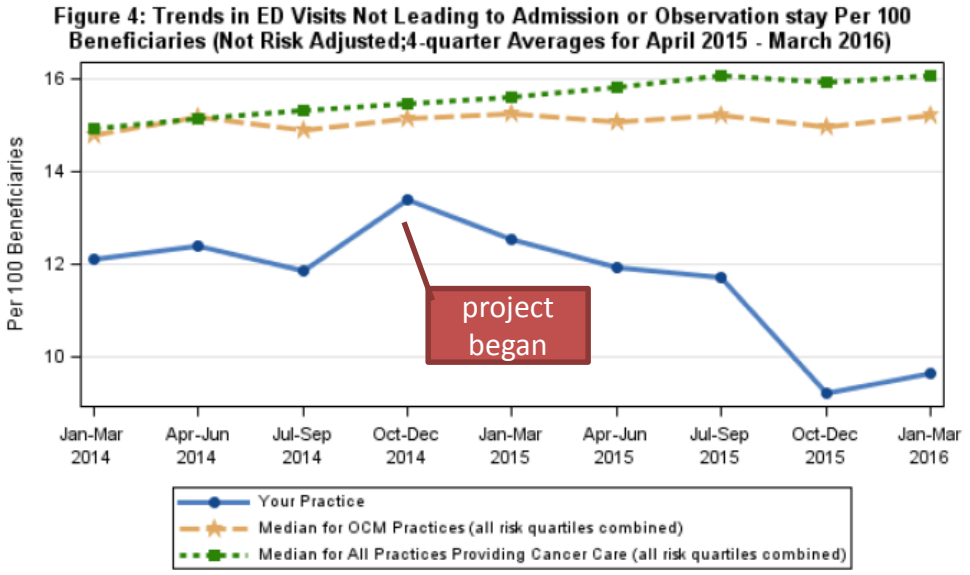
Solution

•Standardized nursing chemotherapy education process including key nursing stakeholders

•Standardized patient education resources utilizing Oncolink

•Nursing education documentation template and smart phrases built in Epic

- Integrate palliative care into clinic

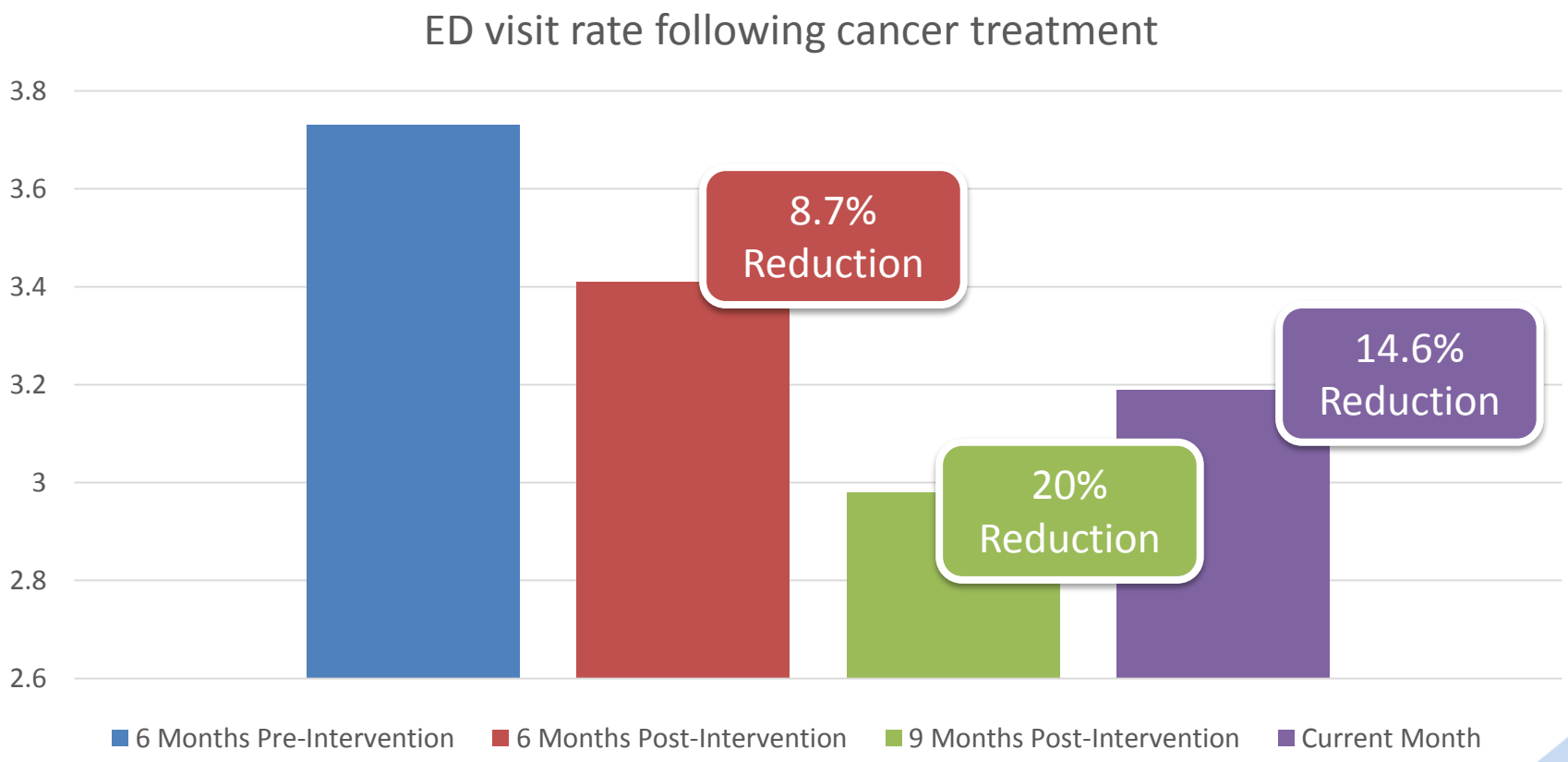


CMS spending per patient per month (risk adjusted, 4 quarter average) OCT-DEC 2016				
Service	**Current Result**	**Change Since Last Quarter**	**Change Since Baseline**	**LGH vs Peers**
ED visits w/o i/p admit	$15	Better	Better	Better +36%

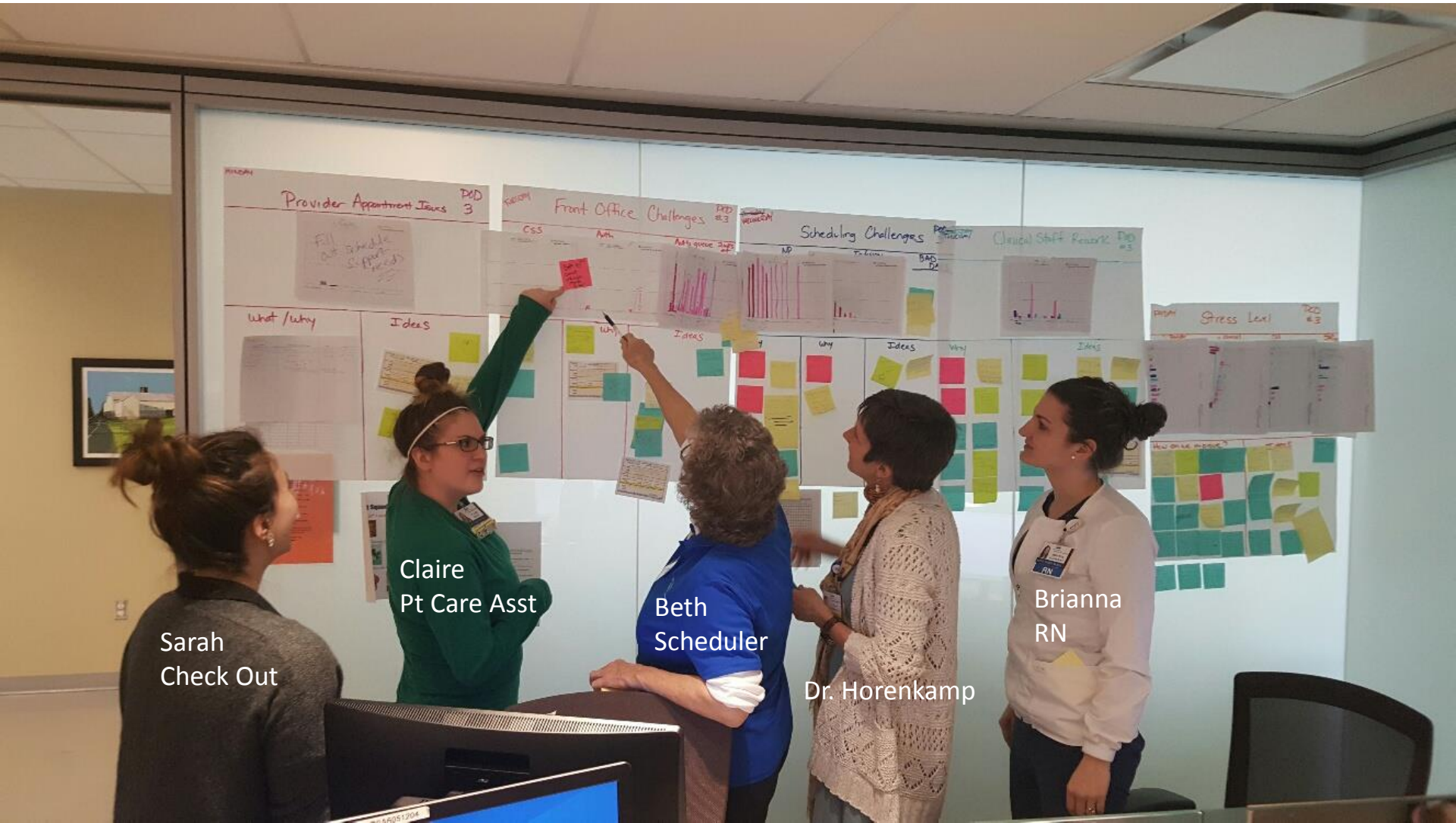
Future Enhancements:

- Redesign oral chemotherapy education process and workflow
- Integrate palliative care into all disease pathways

Clinical Outcomes



Daily Huddle



OCM Requirements - Dr. Abbey Bartlet care team

MRN	Patient	Diagnosis	Episode Start	Next Appointment	Complete Stage in Epic	IOM Care Plan Complete	Depression Screening in past 4 months	ACP Conversation	ACP Documents Received
					Provider	Provider	Care team		
0123456	Fitzwallace, Percy	Colon	September	2/13/2017	YES	10/27/2016	11/28/2016	YES	NO
1234567	Cregg, CJ	Endometrial	September	2/14/2017	NO	11/29/2016	NO	YES	NO
2345678	Bartlet, Josiah	Lung	September	2/15/2017	YES	10/27/2016	11/28/2016	YES	YES
3456789	McGarry, Leo	Prostate	December	2/15/2017	NO	NO	12/15/2016	NO	NO
4567900	Ziegler, Toby	Rectal	August	2/16/2017	YES	12/15/2016	NA	YES	NO
5679011	Seaborn, Sam	Brain	September	2/17/2017	YES	11/29/2016	NO	YES	YES
6790122	Fitzpatrick, Carol	Breast	October	None Scheduled	NA	10/25/2016	11/30/2016	YES	YES
7901233	Landingham, Dolores	Breast	August	None Scheduled	YES	NO	NA	YES	YES
9012344	Concannon, Danny	Thyroid	January	None Scheduled	NO	NO	1/26/2017	YES	YES

ACP = Advance Care Planning

OCM Updates

Week of 2/13/17:

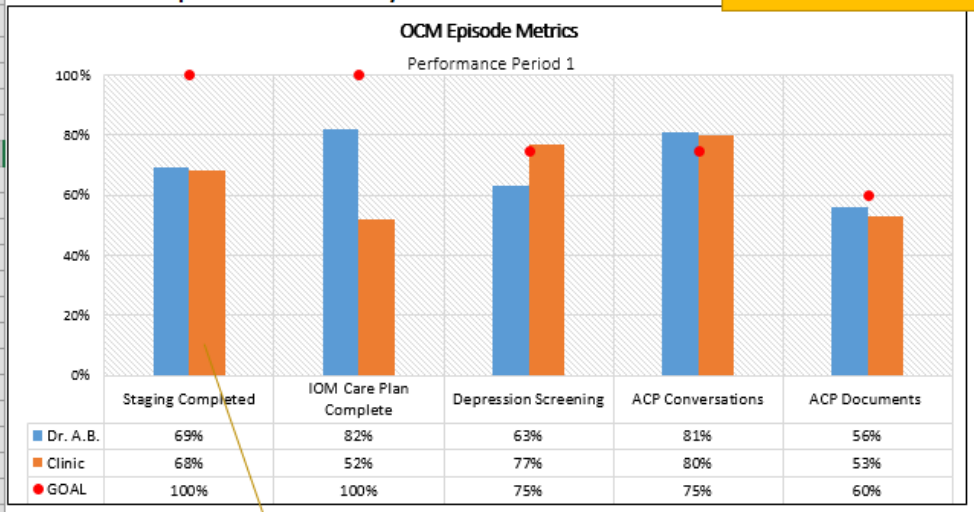
- Individualized price estimates going live
- New rooming tool going live
- Palliative clinic adding days
- Lung cancer pathway updated
- Care plan will pre-populate survivorship
- PCP depression screening doesn't count must do our own at onc visit

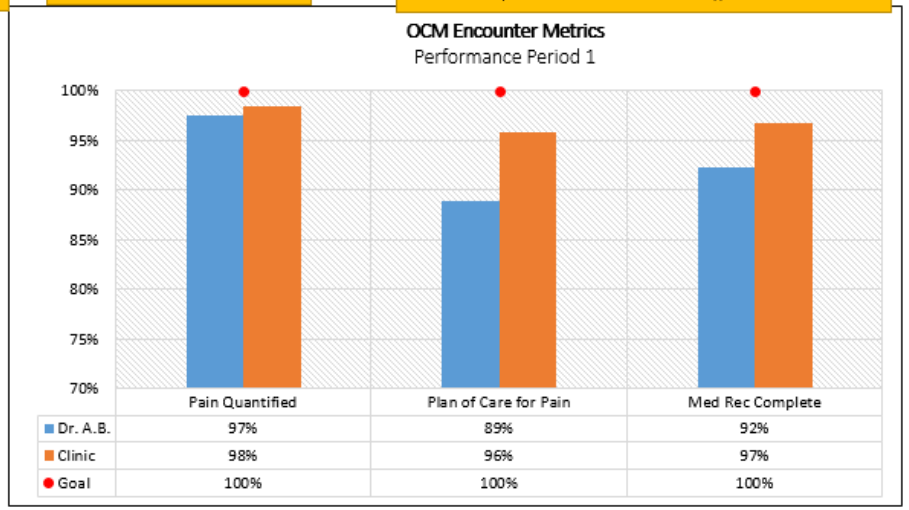
Patients with no next visit are flagged for follow-up

upcoming uncompleted tasks are RED. Patients with all

Distinguish between process measure (did we talk to patient about ACP) vs outcome measure (did patient return ACP documents (was conversation effective))

OCM Clinical Requirements Stats: July-Dec

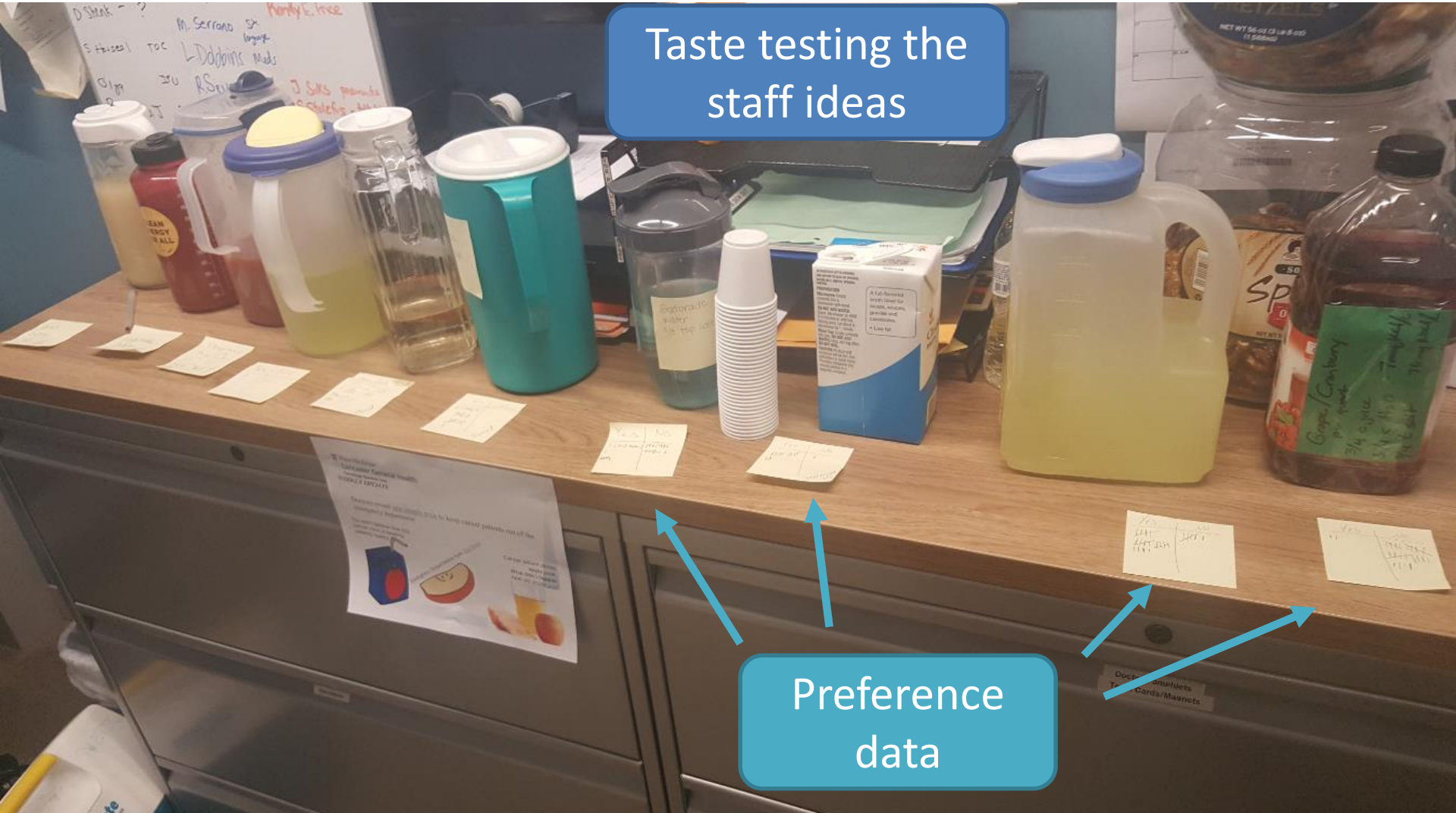




Physician (blue) is compared to peers (orange)

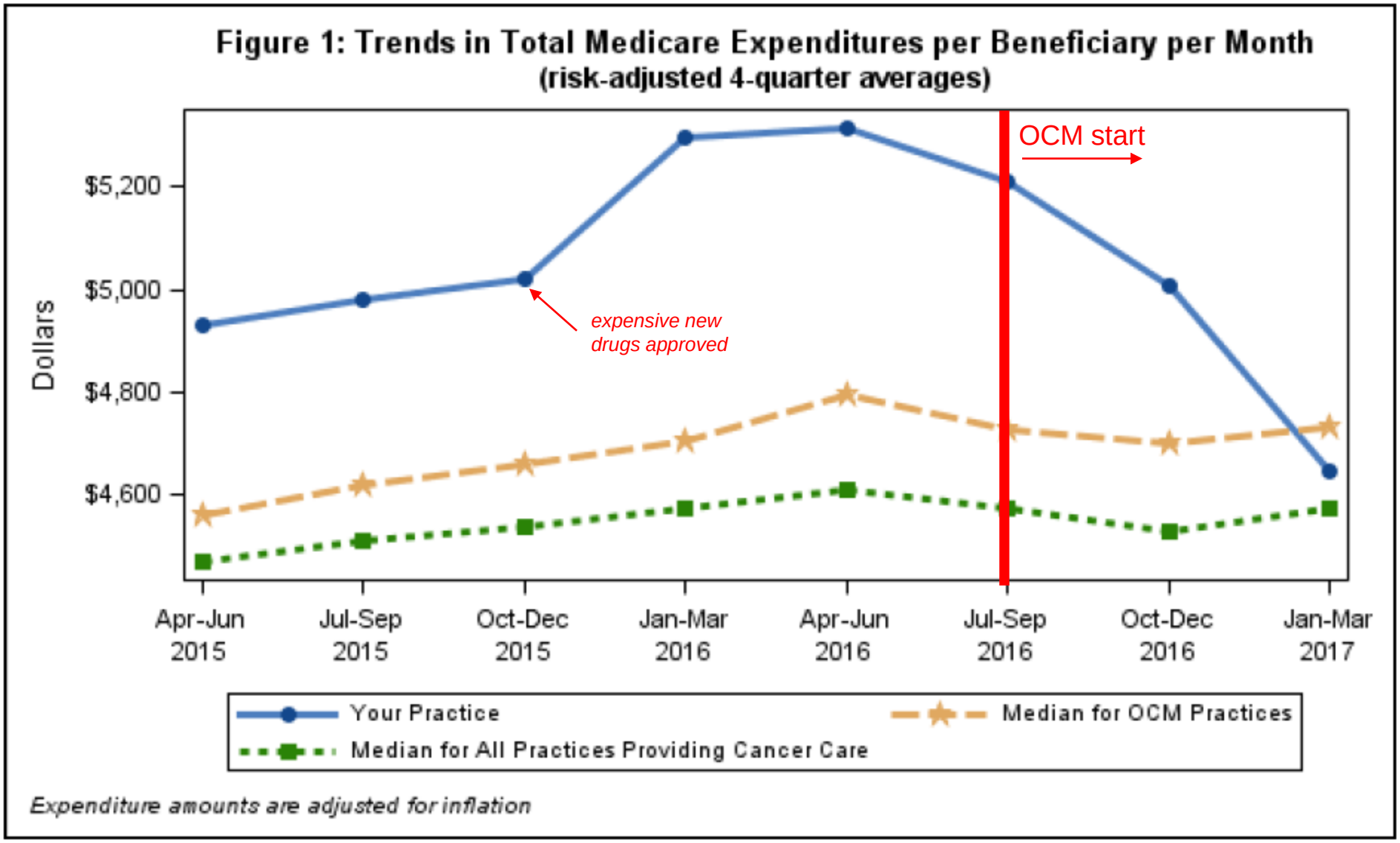
Episode metrics are done once each six months, Encounter metrics @ every visit

Project:
Reducing on-demand hydration visits through better self care

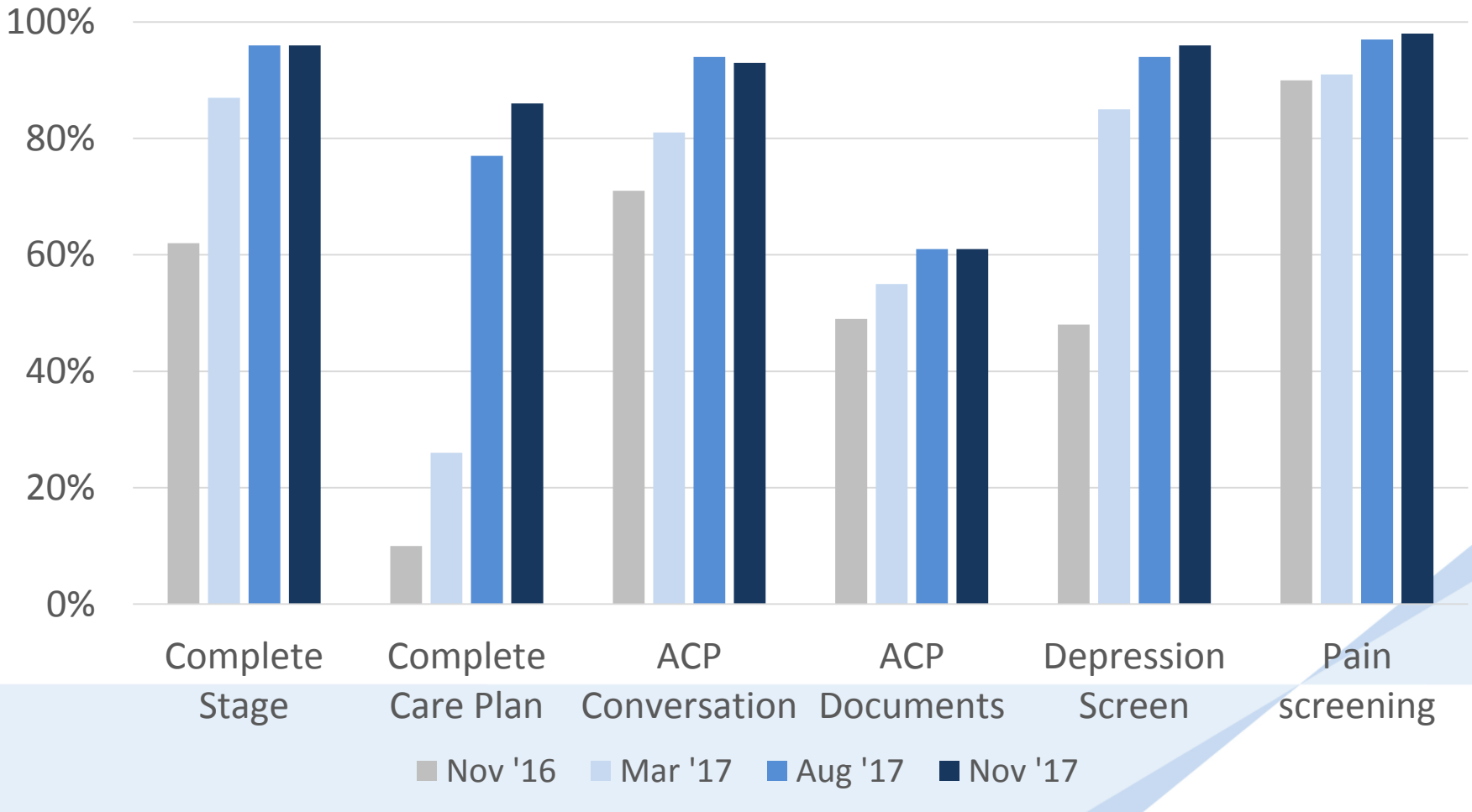


How has OCM impacted outcomes?

…with great results so far!



Key Quality Measures (internal data)



Patient Experience

Table E. Patient Experience Survey, Average of Overall Rating and Composites (risk-adjusted; beneficiaries receiving cancer care January – September 2016)

	Average of Overall Rating and Composites (a)
Your practice	8.81
OCM practices	
Percentiles	
10th	7.96
20th	8.08
30th	8.20
40th	8.27
50th	8.34
60th	8.40
70th	8.46
80th	8.51
90th	8.59
Minimum	6.83
Maximum	8.94

Summary

Keys to OCM Success

- Culture change before process change
- Early IT support and an adaptable EMR
- High level of staff and physician engagement
- Process improvement training
- Protected time for doctors and staff to work on performance improvement projects
- Focused leadership attention
- Co-located services

Benefits Of OCM Participation

- This project helped us change to a culture of rapid process improvement
- Significant improvement in teamwork and morale
- It challenges our cancer program to provide better care to all patients.
  - Emphasis on finding ways to be proactive not reactive
- It promotes innovation and great care and challenges us to ask tough questions
- Care has improved for non-OCM patients too
  - We apply the same care model to all patients so that there is only one standard of care

Recommendations

- Demonstrate outcomes for navigation that can show return on investment at the local level
- Develop standards for structuring navigation programs to maximize outcomes
- Develop and disseminate standard work and expectations on navigation so that all staff can function as navigators in meaningful way and we aren’t relying on a single individual
- Fix the problems that are continually creating barriers for patients